Intake Form

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Past Treatment/Results.	
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#3 Problem/Symptoms:	Children
Co aut trifingli in states and dospets? Yes No Haw often?cares/wegge.	Grandmother - Crandfairer C
Date Symptoms Began:	
	s seek a MoleVi
#4 Problem/Symptoms:	Acina uby everi Acina uby everi
Party and Party Pa	Convolutions of the Control of Co
CONTROL WITH THE PROPERTY OF T	
Date Symptoms Began: Past Treatment/Results:	

Troy Farwell Holistic Health Intake Form

Are you currently receiving ca supplements and prescription	are from any othe drugs below:	r health professio	onal(s)? (Please provide names) Please list a
Is there any chance that you a Do you have any known aller	are pregnant? □\ gies or sensitivitie	Yes □No es (drugs, pollens	, foods, etc)?
Is there any reason you canno	ot ingest herbal re	emedies prepared	d in food grade alcohol? □Yes □No
Have you ever undergone sur	gery or been hos	oitalized? (Please	e provide the date and reason)
Please describe any accidents	or injuries you h	ave sustained in	the last five years:
	<u>Fam</u>	nily Medical Hist	<u>ory</u>
Please complete this section of Age (if deceased, age at death Mother - Father - Siblings - Children - Grandmother - Grandfather - Other:	nly for any family) Health issue	members with p	articular health problems. Relationship
		onal Health Ha	그 그 사람이 하는 사람이 가는 사람이 되었다고 가장 하는 것이 바다 사람들이 모르는 것이다.
Weight 1 year ago: Are you a smoker? Have you smoked in the past?	Weight in your e	arly 20's:	Goal Weight?
Have you smoked in the past?		_ When did you	quit?
DO YOU EXELLISE LECTION Y	L 100		times/week
Type: Carulo	YOGA		
bo you use recreational drugs?		What types?	Strength How often nd?How much?
Do you drink alcohol?	11		

Intake Form

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Do you drink warm or cold		Citysto Julia	Sala sed hair Okrahes
Teach after age assigned in		Elkower bein pain	
Do you drink coffee? □Ye	es □No How often?	What kind?	THE STREET
	Cardiovascular		Dramaking and Co.
Do you drink tea? □Yes □	□No How often?	times/week. What kind?	DECREE SE COLUM
To the best of your ability,	please indicate what you	u typically eat on a daily basis (ple	ease be honest):
Breakfast: what time?	ed coffee and the soft for the	Note year area (page)	State of the
	□ Fainting		
wy the posterior applical? City	Chregular heart beat se		#wbes00
a complete in the amountainess of	500 1691 38 About 1897 Do		
Lunch: what time?	DARKIS SWEIR GEST ST		Barrio Harrio Alla
	DPalpations		LRecent changes
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2	anaraconoliti	4	
Supper: what time?		isonit bre sect	Head Deer J. breit
	A alabama palabahan sa		
	your heart or carrylation		anderFiG
2 1			at seen DC
Snacks:	Gastro-Intestinal		OSIBLOWAR
			KORY ENOUGH
Do you indulge in sweets a much? se	ervings/week.	ow often?times/we	eek. How
	notangibniG	diot; i loddo doddino diid iidiod.	e when.
	CAbdominal Pain		
Rate the strength of your a	ppetite on a scale 1-100	· remines to Topics with	
Rate the strength of your di	idection on a scale 1-100		
	igestion on a scale 1-10.	J	
	alocte of exposition		
	ebro(nompHC)		
	Lab money? probability		
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Intake Form

PART TWO: HEALTH CONCERNS

Please check those issues you have experienced in the last Skin and Hair	st 3 montns. □Swollen glands
□Rashes	Any other problems with your head, eyes, ears, nose
□Poor healing sores	or throat?
□Hives	
□ltching	<u>Cardiovascular</u>
□Eczema	□High blood pressure
□Psoriasis	□Low blood pressure
□Pimples	□Chest/heart pain
□Acne	□Fainting
□Dandruff	□Irregular heart beat
□Hair Loss	□Cold hands or feet
□Recent moles	□Ankle swelling
□Recent changes in skin texture	□Palpations
Any other noted problems with your skin, nails or hair?	□Easy bruising
	□Varicose veins
Head, Eyes, Ears, Nose and Throat	□Blood clots
□Poor vision	☐Breathing difficulties Any other problems with your heart or circulation?
□Floaters	your neart or onculation:
□ Cataracts	Cooking Industrial
□Glaucoma	Gastro-Intestinal
□Blurred vision	□Nausea
□Eye pain	□Vomiting
□Earaches	□Diarrhea
□Poor hearing	□Constipation
□Ringing in ears	□Bad Breath
□Sore throat	□Indigestion
□Canker sores	□Abdominal Pain
□Cold sores, if yes how often?times/year	□Heartburn
□Grinding teeth	□Gas
□Facial pain	□Blood in stools
□Jaw pain	□Mucus in stools
□Mucous in throat	□Rectal pain
□Nosebleeds	□Hemorrhoids
Dizziness	□Bloating
□Frequent colds	□Food cravings

Intake Form

Is the blood? □Dark □Normal □Light	□Poor memory
Do you have premenstrual symptoms? How many days	□Confusion
before your cycle do symptoms begin to manifest? days before period If you have PMS, which	□Insomnia
symptoms apply to you?	□Lower back pain
□Breast tenderness	□Abdominal pain
□Bloating	How many: pregnancies have you had?; births?; miscarriages?; premature
□Weight gain	hirths? abortions?
□Water retention	If you have menopausal symptoms, please describe
□Depression	your major symptoms:
Do you or have you recently used contraceptives? ☐ Yes ☐N	lo If yes what kind?
Are you post-menopausal? □Yes □No	
If yes what is the approximate date of your last period? Do you have any other gynecological issues?	
Neuropsychological Have you ever been diagnosed with a mental health condition If so what and when? Have you ever been hospitalized for any mental health condition	
□Poor sleep	
□Poor memory	
□Numbness, if yes where?	
□Depression	
□Irritability	
□Anxiety	
□Seizures	
□Migraine	
□Headaches	
□High stress levels	
Loss of balance	
□Lack of coordination	
Difficulty concentrating	
□Foggy or spacey feeling	
□Muscle spam/twitching	
How many hours do you sleep each night?	
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Troy Farwell Holistic Health Intake Form

What time do you go to bed? What time do you awake?
How do you sleep? (on back, what side, stomach)
Do you have any other neurological problems?
Mind and Emotions
Are you able to express your feelings and emotions easily? □Yes □No
Is there an excess of stress in your life? □Yes □No If so what is causing you so much stress?
Do you have tools or techniques to relieve stress? □Yes □No
Do you meditate? □Yes □No How often, what style?
Recommendations
1.
2.
3.
4.
5.
6.
7.
8.
NOTES: